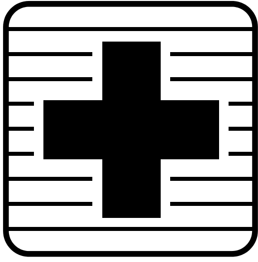

School District of Tomorrow River

HEALTH SERVICES

Heather Schultz, School Nurse

357 N. Main Street, Amherst, WI 54136 Phone(715)824-5523 ext 425 Fax (715)824-5474

Student's Name:

School Attending: **Grade:**

Date: **Bus Student:** Yes (Bus No. __) No

Health Condition: **Bee Sting Allergy (Known) – Emergency Care**

My Child's Reaction May Include:	Do This:
☐ Wheezing, shortness of breath, coughing, Hoarseness ☐ Headache ☐ Itchy skin, hives ☐ Swelling or flushing of lips, throat, tongue, hands and feet ☐ Stomach pain, nausea, vomiting These Signs occur: ☐ Within a few minutes ☐ Within 30 minutes to 2 hours	☐ Observe for 20 minutes, notify classroom teacher ☐ Apply ice to area ☐ *Administer Epi Pen ☐ Immediately ☐ Only when these symptoms are present ___________________ ☐ Student can self-administer Epi Pen ☐ Yes ☐ No ☐ *Administer the following medication Name: ___________________________ Dosage: _________________________ *You must also fill out a medication consent form prior to administration of medications. *** If Epi pen is used 911 and parents will be called.** Epi Pen is kept in: ☐ Locker # ________ ☐ Health Office ☐ Gym Locker # _______ ☐ Other __________

_____Yes _____No **Authorization is hereby granted to release this information to appropriate school and bus personnel and classroom teachers.**

Parent's Signature: **Date:**

School Nurse's Signature: **Date:**